ATLANTIC DIVISION,
NAVAL FACILITIES ENGINEERING COMMAND

ACCIDENT ABSTRACT

Accident Type: Crane Accident
Injury: N/A
Type of work: Barge Mounted Crane
Equipment: 150 Ton Crane on Barge

Description of the Accident:

A 150-ton crane was working on the north side of Pier22. The crane operator was in the process moving to a location where the crane could pull the "spuds" on the barge and while moving forward the crane started to slide. There was no load on the crane. Crane operator turned the crane cab around to see what was happening and the crane slide off the barge into the water. The operator jumped from the cab onto the barge and watched as the crane fell off the barge.

Direct Cause:

1) **Crane not tethered to the barge.**

Contributing Causes:

1) **Snow and ice not removed from the barge deck before going to work**
2) **Crane driver not following the revised crane plan for land mounted cranes on barges.**

Lessons Learned:

1) **Crane not set-up in accordance with the modified crane plan.**
2) **No record of the ROICC office having received the new crane plan.**
3) **Crane was in violation of EM-385 section 16 F.06 by not having a means of a slack tie down system to tether machines travel.**
4) **Superintendent not being responsible for safety on the jobsite.**
5) **No activity hazard analysis was done before starting this phase of the work.**
6) **Start-up inspection checklist not answered correctly as to crane being tethered.**
7) **Operator should have stopped the entire operation because of unsafe conditions.**

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